SENATE PUBLIC HEALTH, WELFARE & SAFETY

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Testimony in Support of a Maternal Mortality Review Panel

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The March of Dimes supports House Bill 28 which will establish a maternal mortality review panel to review maternal deaths.

The March of Dimes Foundation works to improve the health of women of childbearing age, infants and children by preventing birth defects, premature birth and infant mortality through research, community services, education and advocacy.

According to the Centers for Disease Control and Prevention (CDC), maternal mortality in the United States declined markedly during the 20th century, but has declined little during the last 20 years. The earlier, historic decline was led largely by medical and technological advances. In addition, interest and concern at the local, state, and federal levels led to developing systems for identifying, reviewing, and analyzing maternal deaths. These systems have determined causes of deaths, identified gaps in services, and disseminated findings and recommendations. According to the National Center for Health Statistics, this increase may largely be due to changes in how pregnancy status is recorded on death certificates including question formatting and revisions to the U.S. Standard Certificate of Death.

Based on data from the past 13 years, there is an average of nine pregnancy-associated deaths per year in Montana, using the definition of "during pregnancy or within one year after the end of pregnancy." Approximately 40% of those deaths are attributable to obstetric causes. An additional one-third are caused by unintentional injuries, which are among the most potentially preventable causes of death. To put this into perspective, women who have been pregnant within the past year die of injuries three times more often than women of the same age who have not been pregnant, and in particular they die of motor vehicle accidents in which they are the drivers four times more often.

Maternal mortality review should be part of each state's core public health function of assessment. Pregnancy-related death identification and review should be a routine component of the work of the health department. State maternal mortality review committees make important contributions to public health by improving the identification of pregnancy-related deaths; conducting or overseeing the review of these deaths; recommending actions to help prevent future deaths; and synthesizing and disseminating the review results. (Centers for Disease Control and Prevention; 2001)

The purpose of reviewing pregnancy-related deaths is to gain insight into the medical and social factors that lead to such events in order to decrease such deaths in the future.
Although maternal mortality reviews are sometimes conducted by hospital-based peer-review committees that focus strictly on medical events leading to the death, the pregnancy-mortality review process needs to include non-medical as well as medical causes underlying the death. Some states take a systems approach to identifying ways of reducing pregnancy-related deaths. This approach includes looking for problems with the health care system as a whole—

including the public health system—and not merely at individuals or individual practices. (Centers for Disease Control and Prevention; 2001)

Review should occur at the level at which decisions can be made and resources allocated to reduce pregnancy-related deaths. Because pregnancy-related deaths are relatively uncommon, it is usually more appropriate for states to review pregnancy-related deaths than for cities or communities to do so. States are more likely to have a sufficient number of cases to identify any patterns and to keep the proceedings confidential. In addition, states can more easily disseminate results, make recommendations, and take action to decrease pregnancy-related mortality as well as morbidity. (Centers for Disease Control and Prevention; 2001)

The March of Dimes supports HB 28 for its potential though public health surveillance to improve monitoring of maternal health and better inform prevention and intervention strategies. Review will allow medical and public health professionals to learn valuable lessons that will contribute to preventing future deaths.

Sources:

National Center for Health Statistics. Health, United States, 2008 with Chartbook. Hyattsville, MD: 2009.

Berg C, Danel I, Atrash H, Zane S, Bartlett L (Editors). Strategies to reduce pregnancy-related deaths: from identification and review to action. Atlanta: Centers for Disease Control and Prevention; 2001.